YOUTH SUICIDE PREVENTION

(An extract from the article "Youth Suicide Prevention" by Madelyn Gould and Rachel Kramer)

Title: Youth Suicide Prevention
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Youth suicide is the third leading cause of death among 15 to 24 year olds according to the National Center for Health Statistics. This paper reviews the extensive research literature on youth suicide in the United States, its risk factors and evidence-based prevention ideas that have emerged during the past two decades.

PREVALENCE AND RISK FACTORS:

Suicide is uncommon in childhood and early adolescence. Most completed suicides occur between the ages of 12 and 14. Youth suicide has been more common in whites. The highest youth suicide rate is among Native American males. The availability of suicide rates for Latino youth is limited and do *not* appear to be overrepresented among *completed* suicides. Firearms are the most common method of suicide, hanging being second. Information on the prevalence of *completed* suicides is derived from death certificates; unfortunately, there is no analogous surveillance system for non-lethal suicidal behavior in the US except in the State of Oregon where reporting of all *attempted* suicides among persons younger than 18 is mandatory. Within a period of 1 year, approximately 20% of high school students express serious suicidal ideation and 8% make a suicide attempt, of which nearly 3% require medical attention. *Completed* suicide is more common among males, yet *suicidal ideation and attempts* are more common among females. Latino youth living in the United States have higher rates of *suicidal ideation and attempts* than other youth.

Psychological autopsy studies of youth who *completed* suicide consistently find that the vast majority had significant psychiatric problems like depressive disorders, substance abuse disorders, hopelessness and poor interpersonal problem solving ability. A family history of suicidal behavior, prior suicide attempt, high rates of parental psychopathology, nonintact families, parent-child discord, and physical abuse all greatly increase the risk of completed suicide, as well as suicidal ideation and attempts.

Little information is available on the association of socioeconomic status (SES) and suicide. Suicide stories in the mass media, newspaper articles, television news report and fictional dramatizations are followed by a significant increase in the number of suicides in teenagers. Difficulties in school, neither working nor going to school, and not going to college pose significant suicide risk. Social isolation associated with absence from school may facilitate suicide behavior. Gay, lesbian and bisexual young people are at a significantly increased risk for suicidal behavior.

SUICIDE PREVENTION STRATEGIES:

Prevention strategies derive their evidence from two sources: research on the risk factors for youth suicide and evaluation research on existing prevention programs. Strategies resulting from case studies include school-based suicide awareness curricula; screening; gatekeeper training; and crisis centers and hotlines. Risk factor reduction strategies include restriction of lethal means; media education; postvention/crisis interventions; and skills training for youth.

School based suicide awareness curricula have been designed for high school students based on the finding that teenagers are more likely to turn to peers than to adults for support in dealing with suicide thoughts. The main aim is to increase awareness of suicidal behavior to enable teenagers to identify at-risk peers and to facilitate self-disclosure. However, several evaluation studies found equivocal results. This program is not particularly efficient since the majority of students are not at high risk nor have inappropriate attitudes. Serious concerns were raised regarding an increase in maladaptive coping responses and the possibility of contagion. In light of the limitations of school based suicide awareness curriculum programs, emphasis was shifted toward programs that emphasize skill training, including coping abilities and symptom management for students, education of school personnel, and the implementation of screening programs in schools.

Screening identifies high-risk students but with unknown impact on suicide rates and many false positives. The ultimate success of this strategy is dependent on the effectiveness of the referral. Considerable effort must be made to assist the families and adolescents in obtaining help if it is needed. There is some evidence that screening implementation might meet resistance.

Gatekeeper Training involves the education and training of community helpers who come in contact with suicidal youth in both schools (e.g., teachers, counselors, and coaches) and in the community (e.g., pediatricians, clergy, police, and recreation staff) because they are often in a position to be among the first to detect signs of suicidality and offer assistance to adolescents in need. The purpose is to develop the knowledge, attitudes, and skills to identify students at risk; to determine the level of risk; to manage the situations; and to make a referral when necessary. Research examining the effectiveness of gatekeeper training is limited, but the findings are encouraging. No safety issues were raised. By training school personnel and other adults, community resources can be expanded and a supportive environment for children and youth can be created.

Crisis centers and hotlines offer several advantages: They are convenient, accessible and available outside of usual office hours, thereby providing the opportunity for immediate support at a time of an individual's maximum distress. The anonymity of hotlines may allow callers to admit embarrassing things that they would not do elsewhere. They offer the possibility of great efficiency because they can potentially reach suicidal individuals at a final stage. The rationale for hotlines is that the suicide is usually contemplated with psychological ambivalence. Training of volunteer counselors is crucial in this strategy. The overall limited impact may be due to their low utilization in high suicide risk groups (e.g., males). Nonetheless they have been found to decrease the suicide rate by one third in white females.

Several cross-sectional and longitudinal studies indicate the availability of firearms at home significantly increases the risk of completed suicide. **Weapon restriction** results in one-fourth reduction in firearm suicides. Though this reaches the high-risk group effectively, the Second Amendment Right limits its acceptability among some audiences. Potential restrictions regarding hangings per se seem limited.

Media education involves educating reporters, editors and film and television producers about contagion. The CDC published a set of recommendations on the reporting of suicide. This prevention strategy was shown to be successful elsewhere and its greater use in the US is warranted.

The major goals of **postvention programs** are to assist survivors in the grief process since they experience a broad range of psychological sequalae in the aftermath of suicide. A response plan needs to be in place prior to crisis; yet the motivation for development often occurs after the crisis. There are very few evaluation studies of postvention programs and their efficacy is yet to be demonstrated.

Skills training programs cover such areas as coping skills enhancement, communication skills, problem solving and decision-making skills, drug information, stress management, and development of positive healthy adolescent behavior. Though there are few evaluation studies available, some reduction in risk factors and enhancement of protective factors were reported.

During the past 15 years, our knowledge base about the risk factors for youth suicide has increased enormously. The time is ripe to link research to the practice of suicide prevention. The next generation of evidence based prevention programs should include a focus on multiple risk factors, evaluation protocols, and efficacy measurements. Attention should also be directed towards designing prevention programs that reach high-risk populations. The most effective national agenda to prevent suicide should also include strategies to improve individual clinical care.